Department of LABOR AND INDUSTRIES

Published by
Health Services Analysis Section
Olympia, WA 98504-4322

PROVIDER BULLETIN

PB 01-13

THIS ISSUE

Hospital Outpatient Prospective Payment System

TO:

Hospitals
Self-Insurers

CONTACT:

Provider Toll Free
1-800-848-0811
902-6500 in Olympia

James O. King
Senior Health Policy Analyst
PO Box 44322
Olympia WA 98504-4322
(360) 902-4244
(360) 902-4249 FAX

Email:
kinp235@lni.wa.gov

Purpose

This Provider Bulletin describes the department's new hospital Outpatient Prospective Payment System (OPPS).

The hospital Outpatient Prospective Payment System changes the method of payment for hospital outpatient services provided to Washington State Fund injured workers.

The program is effective for hospital outpatient services provided on or after January 1, 2002.

For specific rules covering the program please review WACs 296-23A-0220, 296-23A-0221 and WACs 296-23A-0700 through 296-23A-0780.

Table of Contents

BACKGROUND

What is changing?

The department is implementing a hospital Outpatient Prospective Payment System (OPPS) for payment of hospital outpatient services provided on or after January 1, 2002. Under this new payment method, the department will pay for most hospital outpatient services via Ambulatory Payment Classification (APC) rather than basing payment on Percent of Allowed Charges (POAC).

Why is the department changing how it pays for hospital outpatient services?

The department traditionally paid POAC for hospital outpatient services. This payment method provided the department with only limited means to manage outpatient expenditures and has not provided the expected consistency in procedure coding across hospitals. Because the new payment system requires the hospitals to accurately code outpatient services in order to receive proper payment, the department can:

- better predict costs;
- promote greater uniformity of procedure coding among hospitals;
- track expenditures in specific categories;
- capture better utilization statistics; and
- provide better analysis of trends.

What system served as a model?

The OPPS used by the Center for Medicare and Medicaid Services (CMS, formerly HCFA) served as the model for the department's system.

After several years of study and in-depth consultation with stakeholders, the department developed the APC payment system using the Center for Medicare and Medicaid Services outpatient prospective payment system as a guide. The system requires each outpatient service to be grouped into a payment classification called an APC.

For a complete description of the federal OPPS program see relevant Federal Registers and web sites (42 CFR, Chapter IV, Part 419, et al. at www.hcfa.gov/regs/hopps/default.htm).

Will the department's APC system differ from the APC system used by CMS?

The department intends to follow the rules and guidelines established by the federal OPPS program with few exceptions. The department recognizes that some inpatient-only procedures may be appropriate to be performed on injured workers in an outpatient setting and will pay for those procedures using POAC.

Do these changes affect self-insured employers?

No, self-insurers will continue to pay hospitals using POAC or 100% of allowed charges whichever is applicable. Hospitals are encouraged to submit the same detailed bills to self-insurers to keep the billing information consistent.

PROGRAM INFORMATION

Which facilities/programs are excluded from the initial implementation?

- Rural hospitals;
- Children's hospitals;
- Psychiatric hospitals;
- Rehabilitation hospitals;
- Military & veterans hospitals;

- ❖ Critical access hospitals;
- ❖ Out-of-state hospitals;
- ❖ Ambulatory Surgery Centers;
- ❖ Crime Victims Compensation program;
- ❖ Procedures identified as inpatient-only procedures by CMS that the department has determined are appropriate to be performed in an outpatient setting for State Fund injured workers;
- ❖ Special programs such as Pain Management and Post Acute Brain Injury Rehab Programs; and
- ❖ Outpatient service identified by CMS or the department as a non-APC service such as:
  - Screening mammography;
  - Services for patients with End Stage Renal Disease;
  - Professional services of physicians and non-physician practitioners paid under the Medicare physician fee schedule;
  - Laboratory services paid under the clinical diagnostic laboratory fee schedule;
  - Ambulance services, physical and occupational therapy, and speech-language pathology services.

A current list of the exclusions and their payment methods can be found in the department's "Hospital Services Billing Instructions" manual. Services deemed proper and necessary and excluded from APC payment will be paid using an alternate payment method.

What are the authorization requirements?

All of the department's treatment authorization requirements remain in effect.
The department will allow some procedures to be covered in an outpatient setting that CMS covers only in an inpatient setting. The department will cover these procedures in an outpatient setting if the following criteria are met:

- ❖ The surgeon deems that it is safe and appropriate to perform such a procedure in an outpatient setting; and
- ❖ The procedure meets the department's utilization review requirements.

For information on the utilization review program please see the following:

- WAC 296-20-024 for utilization management authority.
- WAC 296-20-01002 for definition of utilization review.
- WAC 296-20-02700 through 296-20-03002 for medical coverage policies.
- Provider Bulletin PB 00-08, describing the Utilization Review Program.

WACs may be viewed online at www.lni.wa.gov/rules/WorkersCompensation/workerscompensation.htm. Cursor to the Medical Aid Rules section. For Provider Bulletins see www.lni.wa.gov/hsa/hsa_pbs.htm.

What relative weights will the department use?

The relative weights used by CMS will be used for the program. For current relative weights see the CMS web site www.hcfa.gov/medicare/hopsmain.htm.

How was the blended per-APC payment rate determined?

Each hospital's blended per-APC rate was determined using a combination of the average hospital-specific per APC rate and the statewide average per APC rate. For additional information on the formulas used to establish the individual hospital rates see WAC 296-23A-0720 at www.lni.wa.gov/rules/WorkersCompensation/workerscompensation.htm.

Hospitals will receive their blended per-APC rate via separate letter from the department.

PAYMENT INFORMATION

What is the minimum billing information required?

The department uses the National Uniform Billing Committee Data Specifications. For a complete listing of the items required on bills for outpatient services see the "Hospital Services Billing Instructions". The minimum information required to assign an APC to a claim is also listed in the "Hospital Services Billing Instructions" and includes:

- Type of bill;
- Time of coverage;
- Birth date;
- Sex;
- Condition codes;
- HCPCS/ Physicians' Current Procedural Terminology (CPT®[1]) code(s) and modifier(s);
- Service date;
- Revenue code;
- Service units;
- Charge;
- L&I provider account number; and
- ICD-9-diagnostic & procedure code(s).

Only service lines with a HCPCS/ CPT® code will be paid.

Correct Coding Initiative edits will be applied.

What billing form should be used to bill the department?

The department utilizes the UB92 to pay hospital outpatient bills.

What are the documentation and record keeping requirements?

The department follows the documentation requirements of the federal OPPS program.

The patient's medical record must clearly indicate the reasons for performing an inpatient-only procedure.

Wholesale invoices for all pass-through items must be retained in the hospital's files for a minimum of five years. A hospital must submit a hard copy of the wholesale invoice to the department when an individual pass-through item costs $150.00 or more, or upon request. The department may delay payment of the hospital's bill if the department has not received this information.

A current list of the documentation requirements can be found in the "Hospital Services Billing Instructions" manual. See WAC 296-20-02005 for the department's record keeping rules at www.lni.wa.gov/rules/WorkersCompensation/workerscompensation.htm.

How will hospitals be paid?

Hospitals will be paid the sum of the APC payments + any appropriate pass through payments + any applicable outlier payments.

Inpatient-only procedures, if deemed proper and necessary, will be paid using the appropriate POAC.
Partial Hospitalizations, if deemed proper and necessary, will be paid using the appropriate Per Diem rate.

[1] CPT is a registered trademark of the American Medical Association

Covered services normally paid under a fee schedule and not included in an APC payment will be paid using the appropriate fee schedule. All applicable payment caps apply.

How will the department pay for pass-through items?

Hospitals will be paid fee schedule or POAC (if no fee schedule exists) for new or current drug or biological pass-through.

Hospitals will be paid acquisition costs for pass-through devices.

The acquisition cost equals the wholesale cost plus shipping, handling, and sales tax. These items should be billed together as one charge.

Where is more information available?

WAC 296-23A-0220 Department Payment Methods
WAC 296-23A-0221 Payment Methods for Self-Insurers
WACs 296-23A-0700 through 296-23A-0780 OPPS Program Description

- Complete text of these rules can be found at www.lni.wa.gov/rules/WorkersCompensation/workerscompensation.htm
  Cursor to the Hospitals section.

Or, you may call the Provider Hotline 1-800-848-0811 and request copies from the department.
For a complete description of the federal OPPS program see relevant Federal Registers and web sites (42 CFR, Chapter IV, Part 419, et al. at www.hcfa.gov/regs/hopps/default.htm).